

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11805**  
Registrar's No. \_\_\_\_\_

Registration District No. **374**

Primary Registration District No. **4272**

1. PLACE OF DEATH:  
(a) County **North**  
(b) City or town **Denver**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **60 yrs** years, months or days)

3. (a) PRINT FULL NAME **SINNA C. MANNING**  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, **Divorced**  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased **April 27 1868**  
(Month) (Day) (Year)

8. AGE: Years **74** Months **9** Days **22** If less than one day  
hr. min.

9. Birthplace **1 Iowa**  
(City, town, or county) (State or foreign country)

10. Usual occupation **farming**

11. Industry or business \_\_\_\_\_

12. Name **Anna G Manning**

13. Birthplace **1 Ia**  
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Williams**

15. Birthplace **1 Indiana**  
(City, town, or county) (State or foreign country)

16. (a) Informant **J R Bram**

(b) Address **Denver 110**

17. (a) **Buried** (b) Date thereof **Feb 21-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Prairie Chapel**

18. (a) Signature of funeral director **Bram Bros**

(b) Address **Denver 110**

19. (a) **Mar 10-1943** (b) **Arlene Scadden**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **1102** (b) County **North 113**  
(c) City or town **Denver** (If outside city or town limits, write "RURAL") **0**  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **110** (Yes or No) **0**  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **19th**  
year **1943** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Long wound self inflicted with 22 rifle, single shot, Due to end of barrel lodged in mouth. Bullet pierced spinal cord at base of brain.**

Other conditions (Include pregnancy within 3 months of death) **164C**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Suicide**

(b) Date of occurrence **Feb 19, 1943**

(c) Where did injury occur? **Denver, North, Mo.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**On farm**

While at work? **no** (Specify type of place) (e) Means of injury **22 cal. rifle**

23. Signature **Arch C Dingle** (M.D. or other) **same**

Address **Front City, Mo** Date signed **2-20-43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*J P Bran*

Licensed Embalmer No. 2747

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**